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AUTHOR Cole, Lois H.
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ABSTRACT

In order to appropriately assess the needs of the frail elderly, and to establish effective treatment plans and goals, ethnic variables must be considered. Ethnicity can affect individuals in various ways as they age. One's sense of self and perception of others in later life are influenced by the values and traditions of one's ethnic heritage. Ethnicity affects the informal supports and resources available to the frail eldely and their acceptance and use of community services. Nationality, urban or rural background, number of generations removed from immigration, age at immigration, reason for immigration, and the historical period of immigration all have prominent roles in the understanding of frail elderly immigrants. Family relationships and expectations, religion, health and medical care, and nutrition and diet are significant factors in assessing and planning for their care. In dealing with ethnic individuals, it is important to know how various groups approach growing older and meet the changes that come with old age and death. Among different nationalities there are different perceptions of aging, different definitions of problems, and different solutions, especially who is responsible for solving the problems of aging. In the assessment process, workers must consider the elderly client as an individual, a member of a minority group, and also as belonging to a specific ethnic group. (NRB)

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CONSIDERATION OF ETHNIC VARIABLES IN THE ASSESSMENT OF FRAIL ELDERLY

LOIS H. COLE, A.C.S.W.

Coordinator, Riverview Neighborhood Office

The Benjamin Rose Institute

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ABSTRACT

The skills needed to evaluate and assess frail elderly must include an awareness of ethnic variables. Cleveland has a great deal of retained ethnicity, especially on the Near West Side. A large number of persons still prefer and practice their Old Country ways and, yet, they are faced with the realities of a highly organized urban environment. Especially crucial to the evaluation of their problems and needs is an understanding of the ethnic influence regarding family expectations and relationships, health and medical care, nutrition and diet, and religion. The professional's perceptiveness to distinguish between ethnicity and idiosyncrasy is important. A bilingual staff member is a great asset in communicating and being accepted by individuals in ethnic groups.

This paper will focus on the way in which ethnic status effects the evaluation process and establishment of treatment plans and goals. It will offer strategies and techniques for cultural assessment. Case examples will be used for illustration.

INTRODUCTION

In order to assess and evaluate appropriately the functionality and life space of a frail elder, ethnic variables must be made a focus of attention. There has been an increased interest in ethnicity and aging in the last two decades due to the increased numbers of aged and the application of minority and group theories to gerontology. However, research information is still limited and the available findings are often not applied to practice.

In this paper "ethnic group" refers to any of a variety of groups that have a distinctive sense of peoplehood (Gordon, 1964). Furthermore, members of an ethnic group "...conceive of themselves as being alike by virtue of their common ancestry, real or ficticious, or are so regarded by others" (Shibutani & Kwan, 1965). The difference between ethnic groups and minority groups is focus. "The main focus of ethnicity is on cultural continuity, while the focus of minority groups is mainly on equality regarding economic benefits, civil rights, and political rights" (Kolm, 1977).

A review of the literature on aging and ethnicity indicates that ethnicity affects individuals in the following ways. First, a person's sense of self and perception of others in later life are influenced by the values and traditions of their ethnic heritage. For example, in some ethnic groups the woman is the caregiver of parents, of children, and later the caregiver of the spouse. If frailty in later life interferes with the ability to fulfill this role, the person's self esteem may suffer. In contrast, frail older men may have problems if their traditional role is the authority figure in the family yet they are functionally impaired. In brief, problematic areas may arise in later life depending on gender in relation to ethnic background.

Ethnicity also affects the informal supports and resources available to the frail elder. If the elder remains in an ethnic enclave while adult children

have moved to the suburbs, the children may find it distasteful to return to assist elders remaining in the deteriorating and ethnically transitional neighborhood. Around-the-clock care for frail elders is a problem for all families, especially when adult children live at a distance (i.e., suburban areas) and are employed (Fandetti & Gelfand, 1976). However, our experience has shown that a majority of ethnic elderly coming to the attention of agencies have no family ties in the United States which makes their community long term care even more problematic.

Another potential resource is ethnic churches. However, many have also moved to suburban locations. Those that remain in the inner city find that most of their membership live at a considerable distance, so it is difficult to find volunteers to assist frail elderly parishioners.

The acceptance and use of community services are also influenced by ethnic background. A recent study documents that the utilization of formal support services by ethnic elderly is minimal. Specifically, 75% of the Hungarians in the study did not use any formal services. Only 20 to 25% of the Hungarian, Polish, Greek, and Jewish elderly used Medicaid. There was minimal use of food stamps, Meals-on-Wheels or hot lunches, housing subsidies, escort services, counseling, clinics, and nursing services (Guttman, 1979).

Possible reasons for minimal service use by these aged are that self sufficiency and independence are highly valued in some ethnic groups. In others, a stoic attitude is important and thus they feel they must suffer instead of seeking help. Many have negative feelings about discussion of their problems with "outsiders." In some cases, these feelings extend to adult children. Discussing problems with children is seen as a sign of weakness on the part of the elder. In some ethnic groups, going outside of the family for help is seen as inappropriate. In a study of Polish and Italian elderly in Baltimore

(Fandetti and Gelfand, 1976) there was strong agreement "...that the ambulatory elderly individual should live with the family rather than independently or in an institutional setting, such as a nursing home."

Some ethnic elderly, however, are more accepting of church-sponsored services or those from within the ethnic community. Historically, the provision of services for aged was seen as more humane when provided by persons of the same ethnicity as the aged themselves. One study found that the Catholic Church was the first choice of 57% of the elderly respondents for long-term care of the aged outside of the family. Most elderly in this study did live in households with others--often a mutual support arrangement in that the elders did baby-sitting (Fandetti & Gelfand, 1976).

Ethnic elderly may also resist service use because of their perception of what it means to be a "client." Some feel all services are charity and, therefore, stigmatizing. Others are so isolated that they are not aware of available services. Many who did not learn to speak English well find that language is a barrier in obtaining or using services. Ethnic life styles, especially regarding diet and drinking, are often at odds with "good health practice" and consequently impede effective service use. Therefore, "non-compliance" with medical orders and institutional procedures is a problematic area in providing services to frail ethnic elderly.

A final reason that may account for the low level of service use by ethnic aged is a lack of sensitivity to and appreciation for different ethnic heritages on the part of service providers and organizations. This disregard of ethnicities in recent years is decidedly different from the previous three and one-half centuries of experience (Kutzik, 1979) and contributes to the current attitude of disesteem of formal agencies by persons in ethnic communities.

SERVICE SITE: RIVERVIEW NEIGHBORHOOD OFFICE

The information on ethnicity and assessment presented in this paper is primarily derived from the experiences of the Riverview Neighborhood Office staff which serves frail aged in an ethnically diverse geographic area. The area on the Near West Side of Cleveland includes predominantly white Southern and Eastern Europeans who have still retained a great deal of their ethnicity by clustering around their churches. Identifiable groups of significant numbers include: Italians, Polish, Slovaks, Czechs, and Hungarians.

The Riverview Neighborhood Office (RNO), which is a part of the Community Services Division of The Benjamin Rose Institute, is located on the Near West Side. It provides in-home services to frail elderly through multidisciplinary teams of social workers, nurses, home health aides, and geriatric outreach workers to maintain elders in independent community living as long as possible. Team members are guided by systems theory to bring about the utilization of all possible resources: family, friends, and community institutions such as churches, clinics, and social services. An individualized plan is then tailored to meet the complex needs of the client. Family therapy sessions may be a part of the short or long-term goal for each person.

CONTENT OF ASSESSMENT

A number of facts relating to ethnicity are significant to obtain during the assessment of frail elders. First, there is the history of the immigration. A knowledge of what country persons emigrated from provides clues as to behavior in later life. For example, Italian families who rented their land and the Polish families who owned their land both emigrated in family groups. With advancing age, Italian and Polish men show the expected transitions from active to passive roles. In contrast, since the Irish farms were inherited by the oldest son, serfdom was less important and the tradition emphasized initiative

and achievement. They came to the United States individually to obtain employment and pursue a career. Therefore, the concern for achievement among Irish men increases with age (Cohler & Lieberman, 1979).

The reason for immigration is also important to determine during the assessment process. Many immigrants came to the United States for financial gain (i.e., to fulfill the "American dream") and were fleeing poverty and famine. These people are more accepting of services outside their own groups and may even become adept at manipulating the system for their own benefit.

> Mr. L., age 78, was originally referred by a hospital clinic for in-home nursing care and counseling to work through resistance to medical instructions. He was diagnosed as having ulcers of both ankles, diabetes mellitus, peptic ulcer and inactive cirrhosis of the liver due to alcoholism. Mr. L. emigrated from Czechoslovakia in 1950 leaving a wife and daughter there. He entered the U.S. in 1956. A brilliant man, he speaks seven languages, and is a talented artist and musician. In Europe he was a self-employed cabinet maker, but because of physical problems, he was unable to be gainfully employed here since the early 1960's. Consequently, he harbors a tremendous amount of anger and displays a persecution complex. He is extremely demanding and manipulative of all services offered him and is non-compliant with medical advice.

Other aged residents in the RNO area were political refugees escaping from oppressive governments. These persons tend to resist compliance with any system and reject regimentation. They especially resist government guidelines and restrictions and fear that acceptance of financial benefits will enable the government to control their lives. Some carry the scars of imprisonment or confinement to the extent that they can not relate to others and suffer a total withdrawal from society.

> Mr. S., age unknown, a single man, was referred to RNO by the owner of a restaurant where he works as a kitchen helper. Due to pedal edema and leg ulcers he needed medical care and the employer was seeking documentation which would enable him to obtain funding. Mr. S. would answer questions with unintelligible grunts and walk away from staff after a minute or two of questioning. Medical examination and ordering of daily dressings for many weeks established the fact that Mr. S. would not be able to form relationships. Persistence by

> the social worker finally revealed Mr. S. had been a prisoner in a WWII concentration camp where his family had been killed. He had come to the U.S. after the war and had lived reclusively doing menial jobs which required no personal interaction.

The year of immigration provides clues about the historical period and its possible influences if individual factual information is not complete. The age of the person at immigration affects his adjustment and possible assimilation. The younger he was at the time of immigration, the easier was the task of reestablishing himself in the new country. Those who emigrated alone tended to be more independent and somewhat more assimilated into the mainstream. If they came with family or to family members, the family tended to be the central influence in their lives.

Also of importance is whether the person came from urban or rural areas. Those from rural areas had a double transition to make as European immigrants tended to be clustered in the urban areas of the northeastern United States. Many still tried to practice their rural ways and found additional frustrations with urban life. Occupations in the country of origin also played a part in the immigrants' relocation. Those with professional or licensed backgrounds often found obstacles in continuing to practice in the United States as their credentials were not readily accepted here.

Additional information needed in the assessment relates to resettlement in this country. Often, early immigrants settled and worked within their own ethnic enclave and were not particularly aware of other cultures. Even those coming after World War II were able to move into areas (such as Tremont in Cleveland) where their native language was spoken in churches, stores, banks, and medical clinics. They tended to find employment with others of the same nationality--many in manual labor and factories--so that learning English well was not a high priority. Non-working wives knew even less about the English

language and American culture. As elderly widows they are ill equipped to deal with the complexities of managing their own affairs.

Also needed in the assessment is knowledge of the networking for the ethnic individual. Our practice has indicated that an understanding of an ethnic influence regarding family expectations and relationships, religion, health and medical care, and nutrition and diet is especially critical to assessing problems and needs of frail elderly.

Family expectations and relationships are of utmost importance in the understanding of attitudes of ethnic elderly. The following expectations are to be considered:

1. The elderly's expectations for their own role and status in the family, i.e., consultants, arbitrators, or advisors.
2. Expectations of their middle-aged childrens' responsibility to them, i.e., housing, food, etc.
3. Expectations of the elderly as to which child is responsible for the parent's care.
4. Expectations of the elderly as to which home is used if a shared residence is required, i.e., that of their children's or their own.
5. Expectations of the middle-aged children of the role regarding the parents, i.e., arranged marriages.
6. Expectation of the middle-aged children of the role of other relatives toward their parents.

When expectations are in conflict or are dissimilar or are unfulfilled there is lower life satisfaction for all involved. However, the strengths of family relationships are also important and should be considered when evaluating the influence of the above factors.

Next to the family, religion is the most important influence on the ethnic person. Knowledge about the importance of the church in the life of the elderly ethnic individual gives valuable evidence about the attitudes of the person toward life and aging and the available support network. The relationship to the neighborhood church may also be a variable in terms of the client's potential for relocation. A church related home may provide a more protected setting when this becomes necessary due to physical or mental deterioration. This is especially true for those white ethnic southern and eastern Europeans of the first and second generations. The Catholic religion is predominant and many of their activities have centered around the church. The concept of members attending church in their parish has added to this identification. In later life, religion takes on an even deeper meaning as persons prepare for death. However, the significance of the church to different nationalities varies. For example, Italians have not traditionally had as much fervor, unity, and political compatibility within their churches as have the Irish. The Italians have more interest in religious festivals and the social occasions which they represent (Ryan, 1973). This is still in evidence in Cleveland today, especially among the older generation.

Attitudes toward suicide and bereavement are influenced heavily by religion (Kastenbaum, 1979). All of these areas are especially significant to frail elders. If a person is old, ethnic, and terminally ill we need to consider all three variables in dealing with the patient.

Religion becomes more internal as one grows older and is not as obvious outwardly. However, it still has an important influence on the behavior of ethnic elderly. Sometimes religious beliefs are used positively by elders to manipulate others into obtaining their own fulfillment of needs or desires. On the other hand, religion can be a negative factor as elders become angry at the

churches over their failure to fulfill their expectations. With this they further alienate themselves from an important source of support.

With respect to health and medical care, the beliefs and practices of different ethnic groups must be carefully evaluated. Ideas about health, wellness, and illness have a close relationship to the understanding of the ethnic variables in working with frail elderly (Miller, 1982). Folk illnesses and cures are often important in maintaining ethnic identity (Chrisman & Kleinman, 1979). Loss of friends and family may have an even greater affect on ethnics than other elderly and cause serious physical or mental health problems. Some professionals question the value of psychotherapy on elderly especially when ethnic values are unfamiliar to the therapist.

In addition, hospitals are "foreign" to many ethnics as they exist without family supports. The need for awareness of these basic facts is essential to successful treatment of frail elderly ethnic persons. The medical professionals need to re-evaluate their perceptions about various ethnic groups and to incorporate ethnically-based treatments. The attempt to discover what sustains and revives ethnic elderly beyond ordinary prescribed procedures and medications is especially valuable, e.g., drinking wine with the family. Awareness that the perception of good health, the tolerance for pain, and response to illness are different for different cultures can be significant in diagnosis and treatment. In addition, the ethical issues as to the choice of an elder to seek medical attention, follow medical advice, and the right to die make such issues even more complicated.

When the view of health and illness was seen as an individual responsibility, the medical profession tended to resist recognition of full significance of ethnicity for improved health care. In addition, many health care professionals prefer working with younger persons since their emphasis is on

"cure." Coupled with that, the lack of understanding of ethnic cultures and values makes ethnic elderly even more frustrating to work with and encourages labels such as "non-compliant" with medical orders, medications, regular appointments, and hospital routines and procedures (Chrisman & Kleinman, 1979). One needs to consider the cultural conflict of feelings about seeking medical help, taking medications only to make one well, going to the hospital only to die, or to a nursing home when one feels families should provide care.

> Mrs. A. is a 77 year old widow residing alone in her own home. Referral to RNO was made by mailman who was concerned for her and her 79 year old sister, Mrs. S., as the older sister was caring for Mrs. A. who was bedridden. Both women had come to the U.S. in 1950 from the Baltic Sea region of Latvia. They had no other relatives here. Mrs. A. had been hospitalized five months earlier with no specific diagnosis. Consultation with physicians indicated concurrence with treatment plan of PT and HHA services under nursing supervision to enable Mrs. A. to regain strength and be able to ambulate again. This plan was met with resentment by the sister feeling that agency staff thought the client was "lazy." Her perception was that when one was ill he must stay in bed and be cared for until he recuperated. Due to language barrier, the cooperation of their pastor was enlisted, but all such efforts at coordination were resented by the sisters and all service was refused.

Closely related to health and medical care are the effects of ethnicity on nutrition and diet. Nationality foods are stressed as one of the unique aspects of ethnic identification. The adherence to these diet patterns are as significant a part of the ethnic life style as most other cultural values. Ethnic attitudes toward obesity are also important, e.g., an admiration of obesity or the belief that fatness is a sign of good health. Concepts of health foods also differ from culture to culture and affect compliance with physicians' orders regarding diet and acceptance of hospital foods. Ethnic diets which are heavy in sugar and salt (or otherwise highly seasoned) may be difficult to forego for the elderly ethnic. These are of special concern for cardiac, ulcer, and diabetic patients. An unwillingness to change these patterns is often viewed as non-

compliance by health care personnel. One additional ethical issue is the right of a person to refuse to follow instructions or the ultimate of refusing to eat. This can be a means of the elderly individual maintaining control over his life. It may be one of the few choices remaining to a frail elder.

> Mrs. D., an 86 year old widow of Hungarian birth, came to the U.S. in 1952. She was a nurse in Germany in WWI and taught in a nursing school there. In the U.S. she was only able to practice as an LPN. She had prided herself on her appearance and was referred to RNO when she became depressed and developed paranoid ideations about her reflection in the mirror following removal of her teeth. A medical/psychiatric diagnosis revealed Alzheimer's and deterioration two years later necessitated nursing home placement. Subsequently, on two occasions she refused to eat and said she wanted to die. Five months later she expired.

PROCESS OF ASSESSMENT

In the assessment process, clinicians must first consider the elderly client as an individual. Second, consideration must be given to the client's membership in a minority group, and third, as belonging to a specific ethnic group. As in all good clinical practice, workers must be aware of their own ethnic and cultural values. They must evaluate their feelings about cultural pluralism and whether they tend to promote assimilation into the dominant social values or to stress the maintainence of cultural beliefs and practices.

In assessing the cultural values or patterns of clients, workers must not generalize and make assumptions about cultural values because of their client's ethnic identification. In other words, they should test the perceptions which they have by individualizing them with each client and asking questions regarding these areas.

When evaluating the answers, they must bear in mind that all minority people are bicultural to some extent. The conflicts created by this dichotomy may be more important than the cultural facts. Clients later may be helped to become aware of areas which may create social or psychological conflict related to this biculturalism.

Clinicians may want to involve the clients in determining which cultural influences should be considered. They can then identify strengths in the cultural background on which to build treatment modalities. Other aspects may only be of general interest and not relevant to the assessment and treatment plan (Miller, 1982).

In beginning to form relationships, the acceptance of cultural differences--such as residence, diet, and traditional family relationships--is essential. Short-term goals may be to develop a positive feeling of the ethnic elder toward service providers. Caution must be exercised to maintain the delicate line between professional and personal relationships. Objectivity may sometimes be a hindrance in forming relationships with ethnic elders. A positive feeling toward workers may, in turn, be used to dispell fears and beliefs about accepting charity. As in all cases, a goal is to maintain active involvement of the client and family and other collaterals in the treatment plan. The reasons for this are to avoid the dangers of increased passivity and dependence and to improve the self esteem of the frail elderly client. Planning is more difficult when no family exists in close proximity to the elder or when relationships have been strained or broken for many years.

Communication difficulties are a real factor in assessing ethnic elderly. However, the responsibility for communicating rests with the worker, not with the client. A translator often hinders the development of a relationship with the client. Also, the delicate issue of confidentiality is questionable when using an outside person to translate. Family members usually should not be asked to interpret, especially children, because of their place in the family and their emotional involvement. If a translator is used, the worker should try to relate to the client, not the translator.

More important than language is perceptiveness. Workers with experience in

dealing with foreign-speaking clients learn to evaluate in many ways other than language. A formal interview is not the only medium for assessment. One can learn to know the community which is one of the advantages of having an office located in close proximity to the neighborhood served. One can also utilize observations of the surroundings in a home visit, i.e., books, family pictures, religious artifacts, and appearance of the exterior and interior of the home in relation to others in the community. History from collaterals is also a helpful source of information. Often non-verbal communication is as significant as language.

Fluency in the language is not necessary on the part of a worker as most individuals are flattered by any attempt to use their language even if it is halting and ungrammatical. Most importantly, many elderly can understand English if it is spoken slowly with clear enunciation. Diagnostically the inability of the client to speak English may indicate regression. Sometimes it occurs to the point where speaking is no longer possible although the client still may understand most of what is said. The inability to communicate in English may also be a means of resistance and manipulation. It can be used for the denial of a problem or the unwillingness to allow outsiders to invade their private space.

Flexibility in the use of techniques and skills to assess is valuable. It is germane to social work practice to begin where the client is. The ability to understand ethnic groups provides further opportunity for individualization of each client. The assessment of the situation and choice of techniques for intervention are based on this understanding of ethnicity, sensitivity to beginning where the client is, and tailoring goals and treatment plans accordingly. The latter are indicators of the skilled professional worker.

IMPLICATIONS FOR STAFFING AND SERVICE DELIVERY

Staff selected to work with frail ethnic elderly must undergo careful scrutiny in terms of their own feelings and prejudices regarding such persons. These can affect their assessment and determination of goals and treatment plans tailored to the elders' individual needs. A bilingual staff member is a great asset in communicating and being accepted by individuals with strong ethnic ties.

The knowledge of staff members can be expanded through participation in multidisciplinary teams which have experience with various ethnics. In-service training can be a valuable method of obtaining greater understanding of the ethnic variables which are operating. Another means of learning about the particular ethnic groups with whom one is working is to examine formal support systems existing in the community which is served. This can be accomplished through outreach visits. In addition to obtaining information about these organizations, a relationship of trust can be effected between them and the service agency. These relationships can be strengthened by utilizing and reinforcing the existing systems for the referrals and for ongoing service to the frail elder.

Our experience has demonstrated that the service delivery is enhanced by the support and involvement of a multidisciplinary team composed of social workers, nurses, home health aides, and geriatric outreach workers. The individual has the ongoing counsel of a case manager who coordinates services of collaterals and agencies. Treatment plans and goals are established with the involvement of the elder and all collaterals, formal and informal. Supervision of the workers is provided by the team leaders.

CONCLUSION

The focus of this paper was on the ways in which ethnic status affects the evaluation of the frail elder person and the establishment of treatment plans and goals. Additionally, specific strategies and techniques relating to the content and process of assessment were offered.

Studies have reinforced the concept of ethnic variables as significant in assessing frail elderly ethnics in the United States. Nationality, urban or rural background, number of generations removed from immigration, age at which persons immigrated, reason for immigrating, and the historical period of immigration all have prominent roles in the understanding of these persons. Family relationships and expectations, religion, health and medical care, and nutrition and diet are significant factors in assessing and planning for their care. In dealing with ethnic individuals, it is important to know how various groups approach growing older, meeting the changes with old age, and death. Among different nationalities there are different perceptions of aging, different definitions of problems, and different solutions, especially regarding who is responsible for solving the problems of aging.

Implications for staffing and service delivery were presented. These may need to be varied as the ethnic population changes in the future. Research and practice both demonstrate that knowledge of ethnic aging is crucial to the development of programs and services for the aged. An awareness of how cultural variables affect service usage is also essential. Future programs will fail if these are not fully considered.

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